EMPLOYERS' ROLE IN IMPROVING MEDICAL CARE VALUE

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I. The Current Health Care Crisis

A. *The Health Care Cost Crisis*

As we enter the final decade of the twentieth century, health care costs in the United States continue to increase. In 1989, more than $600 billion was expended on health care in America. More significantly, this represents approximately twelve percent of the total Gross National Product, which is double the percentage devoted to health care in 1965 at the advent of the Medicare Program.

Henry Simmons, M.D., M.P.H., President of the National Leadership Commission on Health Care, has predicted current health care expenditures could double by 1995, and redouble by 2001.[1] This would result in a health care bill approaching $2.5 trillion during the first year of the Third Millennium, A.D. Furthermore, the Bush Administration has estimated by the year 2011, when the first wave of "baby boomers" turns sixty-five, expenditures for the Medicare Program alone will exceed those for national defense and social security combined. If the Medicare Trust Fund has not gone bankrupt by 2001, it is expected to be running annual deficits of between $150 and $250 billion.

The current and projected shortfall in federal monies to subsidize the health care industry has necessitated ongoing transfusions from the private sector, in the form of cost shifting. With corporations and consumers paying sixty percent of all health care bills, it is not surprising they are becoming more active in their own efforts to contain costs during the 1990s. Some large

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[1] Personal communication with Henry Simmons, M.D., M.P.H., President of the National Leadership Commission on Health Care (April 3, 1989). The National Leadership Commission on Health was co-chaired by former Presidents Nixon, Ford, and Carter.

corporations, such as Chrysler, which spends more than $6000 per employee on health benefits, have become so frustrated with medical inflation, that they have embraced what only a few years ago would have been banned in Corporate America, national health insurance. Nevertheless, despite the plight of the over 60 million uninsured and underinsured in this country, it was made clear recently with the emasculation of the Medicare Catastrophic Coverage Act,[2] that the American people are not ready to share the financial burden necessary to finance a much more costly federal health insurance program to ensure adequate health insurance coverage for all citizens.

B. *The Health Care Quality Crisis*

Following from and now simultaneous with the health care cost crisis is the health care quality crisis. For many years, the myth was perpetuated that high quality care costs more. As a result of this myth, the health cost containment initiatives by the public and private sectors in the middle 1980s automatically raised fears that underutilization and poor quality would follow. In fact, there have not been any scientifically validated studies to date which have demonstrated that either cost containment measures or programs, such as managed care in which cost containment is an essential component, result in demonstrably worse clinical outcomes. It has been concluded by various researchers, most notably those at the Rand Corporation, that billions of dollars are spent annually on major invasive procedures for inappropriate or equivocal reasons.[3] At the same time, there is mounting evidence that much of the unnecessarily high cost associated with medical care delivery in this country may be attributable to less than acceptable levels of quality. There is an increasing chorus of authoritative voices in this country stating it is the lack of conformance with scientifically validated standards of care delivery which has resulted in the current crisis in cost, quality, and access. If the costs of poor quality could be eliminated or lessened significantly by the development of and adherence to clinical

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[2] Pub. L. No. 100-360, 102 Stat. 683 (1988).

[3] *See generally* Winslow, Kosecoff, Chassin, Kanouse & Brook, *The Appropriateness of Performing Coronary Artery Bypass Surgery* 260 JAMA 509-05 (1988); Winslow, Solomon, Chassin, Kosecoff & Brook, *The Appropriateness of Carotid Endarterectomy* 318 NEW ENG. J. MED. 721-27 (1988).

practice guidelines, there should be enough money and technology available to cover the 60 million uninsured and underinsured Americans.

II. Reasons Behind the Health Care Crises

A. *The Reimbursement System*

Since the early days of health insurance in the 1930s, and accentuated by the passage of the Medicare Law in 1965, health care services have been financed primarily on a "pay-as-you-go" basis. This franchise was granted to the medical and health care industry by Medicare on the assumption that health care was a social good. All Americans were to receive unlimited access to health care services, regardless of the cost. This became the credo of the 1960s.

The 1960s assumption that medical care was a social good gave rise to the proliferating medical schools, hospital beds, and technology of the 1970s. This resulted in the backlash of the 1980s in the form of stringent health care cost containment initiatives and programs. Despite all the efforts of the 1980s, as we enter the 1990s, health care inflation continues to increase. Efforts through utilization review, HMOs, PPOs, and other cost containment techniques have slowed rising costs but have not put an end to them. The reason for the continued increase in costs is that the health care reimbursement system does not and cannot, as presently constructed, reward quality or efficiency in delivery. On the contrary, ineffectiveness, inappropriateness, and inefficiency in the health care system continue to be rewarded.

The new Resource Based Relative Value Scale (RBRVS) is also fundamentally flawed in this respect. Although implementation of the RBRVS over the next five to seven years may lessen to some extent the currently inequitable reimbursement discrepancy between evaluation and management (previously cognitive) and invasive diagnostic and therapeutic services, there will be no mechanism to tie the quality and efficiency of clinical processes and outcomes to reimbursement levels at all. Advocates of the RBRVS felt the systems permitting this type of reimbursement schedule were not sufficiently sophisticated to justify such a payment system. Nevertheless, without some form of effective vol-

ume or utilization restraints, the RBRVS will largely amount to substituting one inflationary reimbursement system for another.

B. *The Health Care Liability System*

The "pay-as-you-go" reimbursement system previously discussed has permitted the past and current liability crises to continue. In the minds of most physicians, to skimp on tests, procedures, and consultations which might help the patient, would put them at an unnecessary risk of litigation. Defensive medical practice, such as ordering tests, procedures, and consultations for medicolegal reasons, as opposed to pure medical reasons, increases the risks of getting sued for nosocomial infections, iatrogenic injuries, breakdowns in medical systems, communication, rapport, and substantial increases in the medically unnecessary and unreimbursed costs to the patient. All of this fuels the litigation system and the vicious cycle continues. The "pay-as-you-go" reimbursement system has provided no countering incentive for providers to be more selective in their utilization of scarce medical resources.

C. *Lack of Medical Intelligence Concerning Clinical Effectiveness*

Despite the billions of dollars invested in medical technology, only a very small fraction of the health care budget has been devoted to determining the relative appropriateness, efficiency, and effectiveness of new technologies for the spectra of clinical conditions for which they are utilized. Indeed, competition in the health care industry, to a great extent, has amounted to providers acquiring the latest and often most expensive medical technologies faster than their peers, and then utilizing and overutilizing them to recoup their investments as quickly as possible. Few, if any, recent expensive technologies have been subjected to cost-effectiveness analyses prior to this form of widespread "competition-driven" proliferation. Such analyses are claimed by critics, who are usually providers but sometimes consumer advocates, to be too time-consuming and inconclusive. Often insurers are criticized by providers and consumers, for failing to reimburse beneficiaries for the use of technology considered to be experimental. The quest for the latest, most elaborate, and expensive medical technologies is part of the gen-

eral malady afflicting the American people. Clearly, this general impatience and impulsiveness has had a great impact on many pervasive societal problems, such as the federal budget deficit, the Savings and Loan debacle, and mounting consumer and corporate debt, to mention but a few.

D. *Lack of Scientifically Validated Clinical Practice Guidelines*

In addition to the relative lack of medical intelligence concerning the clinical effectiveness of most diagnostic and therapeutic technologies, is the rudimentary progress by many medical specialty societies in developing, much less enforcing, scientifically validated clinical practice guidelines or parameters. The American Medical Association (AMA) finally began to coordinate production of specialty-specific practice parameters in 1988. It has recently published a bibliography of approximately 300 practice parameters utilized by twenty-four national medical specialty societies.[4]

Concurrent with the efforts of the AMA and the various specialty societies, have been the efforts of the federal government. The Department of Health and Human Services instituted the Medical Treatment Effectiveness Program (MEDTEP). The ultimate goal of MEDTEP is the development and dissemination of clinical practice guidelines, based upon the demonstration of epidemiologic associations between certain utilization patterns and acceptable, if not optimal, severity-of-illness standardized clinical outcomes. The Agency for Health Care Policy and Research will be the primary distribution point for the greatly increased funds, which may exceed $600 million and will be devoted to the development of practice guidelines over the next five years.

Until effectiveness studies have yielded the results necessary for guidelines to be implemented nationally, some type of utilization controls or expenditure targets will need to be imposed to better manage the current double digit annual increases in Part B of the Medicare Program.[5]

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[4] Personal communication with J.T. Kelly, Office of Quality Assurance, American Medical Association, Chicago (September 18, 1989).

[5] Pub. L. No. 100-360, sec. 201, 102 Stat. 683 (1988).

III. Medical Megatrends in the 1990s

A. *The Age of Medical Information*

As stated earlier, the world in general, but the health care industry in particular, will be impacted during the 1990s by the availability of unprecedented amounts of information. The soon-to-be trillion dollar health care industry will be affected disproportionately because of its size and the intensely personal and intrinsically important nature of the health care transaction.

It is important to understand that not only will the amount of information, but more importantly, the type of information available to health care decisionmakers at all levels of power will change dramatically. Specifically, information will become available concerning not only the cost and relative effectiveness of different diagnostic and therapeutic procedures, but also how cost-efficient various providers in diverse delivery networks are in utilizing these procedures. Use of this information will be extremely valuable in reshaping the health care landscape and power balance.

B. *The Shifting of Power from Providers to Purchasers*

During the 1960s Era of "Medicine as a Social Good" and the 1970s Era of "Technology-Manpower Proliferation" providers were the commodity in short supply and great demand. In such a position, providers exercised tremendous clout in deciding individual transactions with patients and in the health policy arena.

At the beginning of the 1980s, with the publishing of the GMENAC report projecting massive surpluses of physicians in the 1990s and early twenty-first century, the power balance began to shift. As the 1980s Era of "Medical Care Cost Containment" wore on, there was an increasing shift in power from providers to purchasers. Questions continued to be raised concerning medical necessity, appropriateness of procedures, clinical settings, efficiency of utilization, and reasonableness of charges, not to mention the whole concept of indemnity reimbursement. Curiously, despite this power shift and the multitude of cost containment initiatives and methodologies implemented, double digit inflation continued. In fact, perhaps the major impact of the 1980s Era of "Medical Care Cost Containment" has

been to make the 1990s, the Era of "Medical Care Value Assessment and Purchasing."

There are four major reasons why the various cost containment initiatives have not worked. First, there have not been any real incentives for physicians, the productive agents of at least seventy percent of health care expenditures, to become more cost-effective in their clinical decisionmaking. Second, there has not been the capability to evaluate providers' care from the standpoint of both cost and quality in a valid, reproducible fashion. Additionally, cost savings in the inpatient setting have been more than offset by cost increases in the outpatient setting. Finally, the private sector has not yet recognized and exercised its leverage to develop, monitor, and reward preferred provider networks of demonstrably superior value.

Nevertheless, now that we are entering the 1990s Era of "Medical Care Value Assessment and Purchasing," the obstacles to true cost containment with actual improvements in quality should rapidly dissipate. This will occur if providers and purchasers can agree upon the essential principles of medical care value assessment and purchasing.

C. *The Era of Medical Care Value Assessment and Purchasing*

Medical care value purchasing consists of the public and private sectors identifying and contracting with providers which can demonstrate, through similar measurement systems, that they improve the average severity-adjusted clinical outcomes of patients to the greatest extent per purchaser dollar spent.

Medical care value purchasing is possible only through the ongoing collection of timely health care data that is analyzed and reported in useful formats. For medical care value purchasing to work effectively, definitions of provider quality and cost-effectiveness must be mutually agreed upon by providers and purchasers.[6] Systems for measuring provider quality and cost-effectiveness should also be agreed upon by providers and purchasers.[7] Additionally, standards should be created by which se-

[6] J. Couch, Medical Quality Management for Physician Executives in the 1990s: The Era of Medical Care Value Purchasing, American College of Physician Executives 1 (1989).

[7] *Id.*

verity-adjusted provider quality and cost-effectiveness can be compared.[8] Criteria should also be established to be used by purchasers in selecting providers on the basis of their measured clinical performance.[9] Health care benefit programs must be redesigned to create incentives to channel subscribers toward high value providers.[10] Furthermore, provider reimbursement levels must be established and continually adjusted on the basis of the demonstrated value of their health care services to subscribers.[11]

Through the agency of medical care value purchasing, the private sector should become the primary shapers of both health care financing and delivery in the 1990s and early twenty-first century. Faced with a thirty percent increase in health benefit premiums in 1988, and comparable increases projected in 1989, members of the National Association of Manufacturers have a tremendous incentive to adopt the principles of medical care value purchasing to encourage the delivery of both high quality and cost-effective health care by participating network providers. In addition to this incentive, they should have both the clout and the resources, through unprecedented access to useful information concerning the comparative severity-of-illness standardized value of medical care delivered by various providers, to begin to reshape the American health care landscape in the 1990s and early twenty-first century.

IV. Health Care Delivery and Financing in the 1990s and Twenty-First Century

A. *Health Care Delivery*

To cope with the difficulty of increasing demand for universal access to health care of superior value in an era of increasing constraints, it is clear that the major difference in health care delivery by the end of the 1990s will be the widespread adoption of clinical practice guidelines, parameters, or protocols.

The widespread development, dissemination, and adoption of these guidelines will hardly amount to "cookbook medicine," to which so many physicians are vehemently opposed. Rather,

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8 *Id.*
9 *Id.*
10 *Id.*
11 *Id.*

these guidelines will be the result of greatly expanded clinical outcomes and medical technology effectiveness research. This research will involve the epidemiologic analysis and evaluation of large clinical databases permitting scientifically valid linkages between severity-of-illness standardized clinical outcomes desired or expected by the financiers and recipients of health care services and specific patterns of utilization of the latest technologies for a broad spectrum of clinical conditions and illness severities.

As the size of these clinical databases and the informational methodologies for analyzing them continue to increase, physicians will gain the ability to utilize clinical decision support systems, formerly known as medical artificial intelligence, to continuously improve the value of the care they deliver. These medical decision support systems will be driven not only by the latest clinical outcome and effectiveness research, but also by patient preference, utility, prognostic, and other predictive methodologies.

This system is far from "cookbook medicine". The intelligent application of these technologies will permit the highly sophisticated individualized management of each patient, according to patient preference, severities-of-illness, key clinical findings, and predicted effectiveness of various available technologies. This should prevent physicians from using their current cookbook approach of managing most, if not all, patients primarily on the basis of their patients' symptoms alone, without regard to the latest estimate of the relative effectiveness or value of proposed interventions and the preferences, utilities, and values of patients for whom these interventions are being proposed.

B. *Health Care Financing*

It is equally clear, however, that simultaneous with the widespread development and dissemination of clinical practice policies there will need to be dramatic changes in the methods of health care reimbursement and other professional incentives, to provide the impetus for equally widespread adoption of these policies by practicing physicians.[12]

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[12] Lomas, Anderson, Dominick-Pierre, Enkin & Hannah, *Do Practice Guideline Guide Practice? The Effect of a Consensus Statement on the Practice of Physicians* 321 NEW ENG. J. MED. 1306-10 (1989).

For most beneficiaries of the current health care reimbursement system there remains little incentive, financial, professional, or otherwise, to adopt clinical practice policies. Until and unless the reimbursement system rewards providers for demonstrable compliance with these policies and the severity-of-illness standardized clinical outcome standards with which they have been shown to be epidemiologically associated, there will not be widespread implementation of these policies.[13]

In order to initiate changes necessary in the health care reimbursement system to permit the widespread implementation of these clinical policies, large health insurers in cooperation with the federal government, could share confidential access to their large clinical databases with top researchers, universities, and institutes with acknowledged expertise in clinical outcome and effectiveness research for a wide range of medical conditions. The researchers could then share their findings with the large insurers, the federal government, and the various national medical specialty societies involved in clinical policy development. The national medical specialty societies, with ongoing input from the researchers, federal government, and insurers, could then translate the findings into clinical practice policies. Large health insurers and the federal government could begin to implement pilot projects in various geographic areas in which providers would begin to have progressively larger portions of their reimbursement tied to their demonstrable compliance with these clinical policies and expected outcome standards with which these had been previously demonstrated to be associated.

In addition to these changes in the health care reimbursement system, to sustain compliance with clinical policies and expected outcome standards of performance, health benefits programs will need to be changed simultaneously. Strong financial incentives and disincentives will need to be imposed to channel most, if not all, employees into plans of demonstrably superior value. Through these differential incentive schemes, physicians either unwilling or unable to comply with clinical policies and their associated outcome standards of performance should find it financially unattractive to continue to practice medicine in the unmanaged manner they have in the past. To the

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[13] *Id.*

extent that they continue their noncompliance, they will voluntarily drop out of progressive health plans adopting these new reimbursement policies. Eventually, after most major plans adopt these policies, these physicians will be forced out of practice.

V. Probable Impact on Medical Liability and Plaintiffs' Lawyers

Many of the same physicians who will either be unable or unwilling to comply with the latest clinical policies are likely the same physicians who currently, or in the future, find themselves, most often involved in medical liability actions. The Pareto Principle, or other variants of the "20/80" rule, predicts that twenty percent of one agency may be responsible for up to eighty percent of an outcome. With allowances for factors such as the differences in specialties and their inherent risks, regional and environmental forces, general and specific economic conditions, the ratio between lawyers and physicians and the general population, and other assorted potentially confounding influences, an argument can be made that the "20/80" rule may well apply in medical liability.

If twenty percent of the more than 600,000 physicians in this country who may be involved in up to eighty percent of medical liability actions could be financially pressured out of medical practice through changes in the delivery and financing of health care, the incidence of medical liability recoveries could be substantially reduced in this country. This especially would be true, if physicians' demonstrable compliance with the latest clinical policies could be used as strong evidence of having met the applicable standards of care. National adoption of and substantial compliance with these policies by most physicians, therefore, could effectively minimize the success of medical liability actions in America.

For the remaining medical liability actions, perhaps twenty percent, involving particularly severe clinical outcomes despite demonstrable compliance with the latest clinical policies, there could be one of several approaches implemented as part of employee health benefits agreements to avoid the lengthy, costly, and often irrational results of medical injury litigation. One option is requiring binding arbitration, conducted with the assistance of a skilled arbitrator obtained through the American

Arbitration Association. A second option is subjecting disputes to mediators who could negotiate settlements between injured employees and participating network providers. Disputes could also be submitted to an impartial expert panel consisting of physicians, lawyers, and lay people. Another available option is offering fixed medical injury payment benefits, without regard to the assignment of negligence of fault, similar to workers' compensation. The payment schedules of these benefits could be substantially augmented by an actuarially determined amount commensurate with the extent of payments made by injured employees into medical adversity insurance funds through flexible cafeteria-style benefits plans or payroll deductions.

Employers could make it so financially attractive for employees to choose one or more of the foregoing options, that the much costlier, lengthier, and less predictable litigation route would become a thing of the past. Steering employees away from litigation through financial incentives, as opposed to prohibiting access to the courts, should withstand any constitutional challenges.

The impact that the foregoing changes will have on personal injury litigation attorneys, in general, and plaintiff's attorneys in particular, should be dramatic. Considering the direct and indirect costs associated with misguided defensive medical practices of medical litigation already totaling as much as $80 billion, it is clear that to compete effectively in the global marketplace against the Pacific Rim, a united Europe, and a neocapitalistic Eastern Bloc of nations, Corporate America will certainly be predisposed to implement the kinds of changes described here. Given their relationships with large insurers, medical defense lawyers may be able to offer their expertise in the medical care evaluation, risk management, and employee benefit redesign areas. These attorneys will need to begin to reorient their skills and priorities soon to avoid losing this opportunity open to them in the 1990s and early twenty-first century.

Plaintiffs' attorneys, especially those specializing in medical liability actions, will need to reorient their priorities and focus dramatically to be able to survive professionally to the extent to which they have become accustomed during the litigious 1970s and 1980s. They may be able to reorient themselves into various consulting areas to help insurers and other major purchasers of

health care to evaluate, select, and retain only those providers of superior value with the lowest risk of medically injuring employees due to negligence. Given their extensive experience in dealing with the physicians most involved in litigation, they could also be valuable educators of physicians concerning avoidance of litigation.

If Corporate America began to implement even some of the initiatives discussed in this article by the beginning of the Third Millennium, A.D., medical liability litigation should assume its rightful place in the archives of American Folklore.